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STATEMENT OF

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The American Legion
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Before the

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES) COMMISSION
ON

THE NATIONAL CARES PLAN

August 12, 2003

Mr. Chairman and Members of the Commission:

Thank you for the opportunity today to express the local views of The American Legion on the Department of Veterans Affairs' (VA's) Capital Asset Realignment for Enhanced Services (CARES) initiative as it concerns Veterans Integrated Services Network (VISN) 10. As a veteran and stakeholder, I am honored to be here today.

The CARES Process

The VA healthcare system was designed and built at a time when inpatient care was the primary focus and long inpatient stays were common. New methods of medical treatment and the shifting of the veteran population geographically meant that VA's medical system was not providing care as efficiently as possible, and medical services were not always easily accessible for many veterans. About 10 years ago, VA began to shift from the traditional hospital based system to a more outpatient based system of care. With that shift occurring over the years, VA's infrastructure utilization and maintenance was not keeping pace. Subsequently, a 1999 Government Accounting Office (GAO) report found that VA spent approximately $ 1 million a day on underused or vacant space. GAO recommended, and VA agreed, that these funds could be better spent on improving the delivery of services and treating more veterans in more locations.

In response to the GAO report, VA developed a process to address changes in both the population of veterans and their medical needs and decide the best way to meet those needs. CARES was initiated in October 2000. The pilot program was completed in VISN 12 in June 2001 with the remaining 20 VISN assessments being accomplished in Phase II.

The timeline for Phase II has always been compressed, not allowing sufficient time for the VISNs and the National CARES Planning Office (NCPO) to develop, analyze and recommend sound Market Plan options and planning initiatives on the scale required by the magnitude of the CARES initiative. Initially, the expectation was to have the VISNs submit completed market plans and initiatives by November 2002, leaving only five months to conduct a comprehensive assessment of all remaining VISNs and develop recommendations. In reality, the Market Plans were submitted in April 2003. Even with the adjustment in the timeline for four months, the Undersecretary for Health found it necessary in June 2003, to send back the plans of several VISNs in order for them to reassess and develop alternate strategies to further consolidate and compress health care services.

The CARES process was designed to take a comprehensive look at veterans' health care needs and services. However, because of problems with the model in projecting long-term care and mental heath care needs into the future, specifically 2012 and 2022, these very important health care services were

omitted from the CARES planning. The American Legion has been assured that these services will be addressed in the next "phase" of CARES. However, that does not negate the fact that a comprehensive look cannot possibly be accomplished when you are missing two very important pieces of the process.

The American Legion is aware of the fact that the CARES process will not just end, rather, it is expected to continue into the future with periodic checks and balances to ensure plans are evaluated as needed and changes are incorporated to maintain balance and fairness throughout the health care system. Once the recommendations have been approved, the implementation and integration of those recommendations will occur.

Some of the issues that warrant The American Legion's concern and those that we plan to follow closely include:

- Prioritization of the hundreds of construction projects proposed in the Market Plans. Currently, no plan has been developed to accomplish this very important task.
- Adequate funding for the implementation of the CARES recommendations.
- Follow-up on progress to fairly evaluate demand for services in 2012 and 2022 regarding long-term care, mental health, and domiciliary care.

VA HEALTHCARE SYSTEM OF OHIO – VISN 10 – EASTERN MARKET

The VISN 10 Eastern Market consists of 24 counties, 10 of which are rural and 14 urban. It includes the Cleveland VA Medical Center (VAMC) and several Community Based Outpatient Clinics (CBOCs). The Cleveland VAMC is comprised of two divisions, one in Brecksville and one in Wade Park, with two large, outdated physical plants that are in desperate need of renovation. The proposal is to consolidate and collocate all clinical and administrative functions at the Wade Park Division.

While The American Legion supports this consolidation, transportation may prove to be a problem for many veteran patients. Currently, there is limited bus service to the Wade Park Division from counties South and East of Cuyahoga. Many veterans will have a difficult time getting to the hospital. Therefore, The American Legion advises that any plans for consolidation include improvements to the current transportation and parking plans.

Additionally, VA is proposing enhanced use leasing of the Brecksville property. This is a very lucrative piece of property for commercial development. However, any sale or lease of VA property must serve to enhance access to care for veterans rather than simply contribute to the current downsizing of VA.

The CARES data indicated a significant gap in access to tertiary care. In fact, in this market, it fell short by 61% and 40,467 enrollees in meeting the access to care criteria. The proposal to meet the access gap is to either contract in the community for local non-VA inpatient beds or develop community-sharing agreements. Mercy Hospital in Canton, Ohio has been selected to provide that care. The American Legion understands that until the consolidation of the two divisions occurs, this Market is within the access guidelines. The contracting of care needs to be done before the consolidation to ensure no services are suspended during the consolidation. The care of veterans should not be interrupted during this transition. Additionally, The American Legion believes excessive contracting of care should be avoided.

The proposal to collocate with the Veterans Benefits Administration (VBA) is a step in the right direction for this area. The timely accomplishment of compensation and pension examinations and access to specialty doctors would certainly help to expedite the time it takes to adjudicate a veterans claim right, the first time. Additionally, the veteran will not have to travel to separate locations. However, these same ends could be accomplished with the opening of a Community Based Outpatient Clinic (CBOC) at the VA Regional Office (VARO) in downtown Cleveland.

We appreciate this opportunity to appear before you today, and thank you for your kind reception of our views.

STATEMENT OF
LESLIE A. JAMES
NATIONAL SERVICE OFFICE SUPERVISOR
DISABLED AMERICAN VETERANS
BEFORE THE
CAPITAL ASSETS REALIGNMENT FOR ENHANCED SERVICES COMMISSION
CLEVELAND, OHIO
AUGUST 12, 2003

Mr. Chairman and Members of the Commission:

On behalf of the members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views on the proposed Capital Assets Realignment for Enhanced Services (CARES) Market Plans for this area in VISN 10.

Since its founding more than 80 years ago, the DAV has been dedicated to a single purpose: building better lives for America's disabled veterans and their families. Preservation of the integrity of the Department of Veterans Affairs (VA) health care system is of the utmost importance to the DAV and our members.

One of VA's primary missions is the provision of health care to our nation's sick and disabled veterans. VA's Veterans Health Administration (VHA) is the nation's largest direct provider of health care services, with 4,800 significant buildings. The quality of VA care is equivalent to, or better than, care in any private or public health care system. VA provides specialized health care services—blind rehabilitation, spinal cord injury care, posttraumatic stress disorder treatment, and prosthetic services—that are unmatched in the private sector. Moreover, VHA has been cited as the nation's leader in tracking and minimizing medical errors.

As part of the CARES process, VA facilities are being evaluated to ensure VA delivers more care to more veterans in places where veterans need it most. DAV is looking to CARES to provide a framework for the VA health care system that can meet the needs of sick and disabled veterans now and into the future. On a national level, DAV firmly believes that realignment of capital assets is critical to the long-term health and viability of the entire VA system. We do not believe that restructuring is inherently detrimental to the VA health care system. However, we have been carefully monitoring the process and are dedicated to ensuring the needs of special disability groups are addressed and remain a priority throughout the CARES process. As CARES has moved forward, we have continually emphasized that all specialized disability programs and services for spinal cord injury, mental health, prosthetics, and blind rehabilitation should be maintained at current levels as required by law. Additionally, we will remain vigilant and monitor the VA to ensure that their focus is on the most important element in the process, enhancement of services and timely delivery of high quality health care to our nation's sick and disabled veterans.

Furthermore, local DAV members are aware of the proposed CARES Market Plans and what the proposed changes would mean for the community and the surrounding area in VISN 10. In the Central area, gaps were noted in hospital care access, capacity shortage, primary care

capacity shortage, domiciliary enhancement and vacant space. As for the Central market, the main focus is the expansion of the Columbus Outpatient Clinic into a fully operational VA Medical Center (VAMC). The executive summary provides an Ambulatory Specialty Care Center, expected in 2005, which would help address the lack of access to surgical care. Moreover, it would help to eliminate the need for disposition of veterans and their families to remote VAMCs for outpatient surgical procedures. Additionally, the idea of expanding the care to local community providers and hospitals has been acknowledged. The access gap for veterans in the Central market has been identified as only 39% of all enrollees that are within 60 minutes of hospital care. We feel that Columbus, Ohio, one of the largest cities in the country in terms of veterans' population, without a VAMC, is in a desperate need for the evolution of the community-based outpatient clinic (COPC) into a full-fledged VAMC that can provide quality care needed by these veterans.

In the Eastern area, the gaps were identified as access to hospital care, primary care, specialty care, and inpatient medicine. The consolidation of the Brecksville and Wade Park facilities is expected to provide the solution to these gaps by providing a significant reduction in operating costs and transportation costs. As it stands now, patients are seen for primary appointments at the Brecksville VAMC and then sent to the Cleveland Wade Park Campus for all specialized or diagnostic testing. The consolidation is expected to remedy this problem for accessibility. Additionally, similar to the solutions proposed in the Central area, the Eastern area is looking toward contracting with local medical centers to provide specialty care. This is expected to provide for a major reduction in spending for the Cleveland area VA Medical Centers.

The Western area encompasses two VAMCs within 60 miles of each other. Even with the close proximity, specialty care and inpatient care were the main areas of concern for both the Cincinnati and Dayton VA Medical Centers. In an effort to address this need, the planners have offered a plan to expand a majority of the VA CBOCs in an effort to enable more of the veterans in their own community more specialty care. Additionally, a two-floor expansion is slated for the Cincinnati VAMC, to be allocated as specialty care clinics. However, the most prominent focus of collaboration was the inaccessibility to the Cincinnati VAMC due to parking constraints. Because the Cincinnati VAMC is located in a residential area, it leaves limited ability to expand and to incorporate a better parking situation. Current ideas include branching out to the University of Cincinnati and attempting to contract additional spaces. In contrast to the other areas, the Western area has concluded there is no gap in the accessibility issue for veterans in the Western market.

In essence, we concur with the solutions proposed to realign the resources in VISN 10. We feel the solutions are a straightforward and common sense approach to the aforementioned gaps. The main focus is primarily the accessibility of care, whether standard (primary) care or that of a special nature. If veterans are unable to access the necessary medical care they are in need of, then the entire point of providing medical services to those who served is frivolous. The aforesaid proposals incorporate the ability to both redirect funding to allow for more access to the veterans in VISN 10 as well as the accessibility to specialized care through private and/or continued VA means. The outcome expected is that for which CARES was established: to enhance services by providing the best care possible to veterans with the resources available and

to project these needs. Together with the DAV, we concur with the proposals for VISN 10 and look forward to implementation of these proposals.

In closing, the local DAV members of VISN 10 sincerely appreciate the CARES Commission for holding this hearing and for its interest in our concerns. We deeply value the advocacy of this Commission on behalf of America's service-connected disabled veterans and their families. Thank you for the opportunity to present our views on these important proposals.